STATE OF TENNESSEE
EMPLOYEE SICK LEAVE BANK
FIRST FLOOR, JAMES K. POLK BUILDING
505 DEADERICK STREET
NASHVILLE, TENNESSEE 37243-0635
TEL. (615) 741-5431 1-800-221-SEIL (7345)
FAX (615) 401-7667

SICK LEAVE BANK MEDICAL CERTIFICATION

COMPLETED FORM MUST BE MAILED OR FAXED BY THE MEDICAL OFFICE DIRECTLY TO THE SICK LEAVE BANK AT THE ADDRESS ABOVE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Sick Leave Bank to make all necessary investigations concerning this application. I further authorize the release of any records or information, including but not limited to medical, Workers' Compensation, State Retirement, or Social Security disability that is sought in connection with this application.

Patient's Name and SSN (Please Print) _____ Patient's Signature (or legal representative) _____

Name of Medical Doctor/Surgeon (Please Print): _____

Part I: Initial Form: Part I and Part II (Entire Form) completed by the medical doctor/surgeon only.

1. HISTORY (Please answer all questions.)
   (a) When did symptoms first appear or accident happen?..... Mo. ____ Day ____ Yr. ____
   (b) Is this a work-related injury or illness with the state?..... Yes ____ No ____
   (c) Is this a work-related injury or illness with another employer?..... Yes ____ No ____
   If yes, name, address, and telephone number of the non-state employer.
   _____
   (d) Has patient ever had the same or a similar condition?..... Yes ____ No ____
   If yes, state when and describe.
   _____
   (e) Was the patient referred to you by another medical doctor/surgeon? ..... Yes ____ No ____
   If yes, list the referring medical doctor/surgeon's name and telephone number.
   _____
2. PRESENT CONDITION (Please answer all questions.)
   (a) Is patient's present condition the same condition or related to, resulting from, or recurring from a previously diagnosed condition for which he/she previously received treatment? ..... Yes ____ No ____
   If yes, what condition and/or diagnosis? _____
   (b) For the present condition, was the patient: Hospitalized?..... Yes ____ No ____
   Had Surgery? Yes ____ No ____ If yes to either, please list all dates.
   _____

REQUIRED: Patient's Name and SSN (Please print): _____

Part II: For follow-up visits: Part II completed by the medical doctor/surgeon or nurse practitioner/physician's assistant.

3. DIAGNOSIS (Be specific – Please provide the ICD–9 code(s) and a written description.):

Primary diagnosis: _____ _____
ICD-9 Description

Secondary diagnosis: _____ _____
ICD-9 Description

4. TREATMENT (Please describe the treatment): _____

_____

5. APPOINTMENT INFORMATION: (Current Condition)

(a) Date of first visit for this condition? ..... Mo. ____ Day ____ Yr. ____

(b) Date of next visit? ..... Mo. ____ Day ____ Yr. ____

(c) Was patient seen today? Yes ____ No ____ If no: Date of last visit? ..... Mo. ____ Day ____ Yr. ____

6. EXTENT OF DISABILITY FOR PATIENT'S REGULAR OCCUPATION:

(a) What is the usual recovery period for this condition? _____

(b) Is the patient temporarily unable to perform any duties of his/her job? ..... Yes ____ No ____

If yes, beginning date: _____ ending date: _____.

If no, when was patient able to return to work? ..... Mo. ____ Day ____ Yr. ____

(c) When will the patient be able to return to work with restrictions?
Approximate Date: _____ Indefinite: _____ Never: _____

(d) When will patient be able to return to work without restrictions?
Approximate Date: _____ Indefinite: _____ Never: _____

The first Medical Certification Form (initial form for this condition) completed for this patient requires the signature of a Medical Doctor/Surgeon.
Forms based on follow-up visits to your office require the signature of a Medical Doctor/Surgeon or a Nurse Practitioner/Physician's Assistant.

I hereby certify that the above information is true and correct and that the information provided is objective medical information relative to this patient's application to the Sick Leave Bank.

PLEASE PRINT:

Name: _____ _____
Medical Doctor/Surgeon Signature and Title

Address: _____

Address: _____ _____
Date

Telephone #: (____)_____

Fax #: (____)_____